Executive summary

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As part of its mandate from the Congress, each June the Commission reports on improvements to Medicare payment systems and issues affecting the Medicare program, including changes to health care delivery and the market for health care services. The six chapters of the June 2024 report cover the following topics:

- ***Approaches for updating clinician payments and incentivizing participation in alternative payment models.*** The Commission considers two approaches for updating fee-for-service (FFS) Medicare's physician fee schedule (PFS) payment rates and contemplates temporarily extending the bonus for participation in advanced alternative payment models (A–APMs).
- ***Provider networks and prior authorization in Medicare Advantage.*** The Commission discusses the use of provider networks and prior authorization in Medicare Advantage (MA) plans, CMS's regulation of these tools, and the data that MA plans currently report in these areas.
- ***Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources.*** Using data from 2020 and 2021, the Commission assesses the relative completeness of MA encounter data and other data sources that contain information about MA enrollees' use of services.
- ***Paying for software technologies in Medicare.*** The Commission reviews the Food and Drug Administration's (FDA's) process for clearing software as a medical device (SaMD), examines Medicare's current coverage process and payments for medical device software under the payment systems for Part A and Part B services, and discusses issues that policymakers should keep in mind when considering paying for medical software in FFS Medicare.
- ***Considering ways to lower Medicare payment rates for select conditions in inpatient rehabilitation facilities.*** The Commission considers alternative approaches to lower FFS Medicare's payment rates to inpatient rehabilitation facilities (IRFs) for beneficiaries with select conditions.
- ***Medicare's Acute Hospital Care at Home program.*** The Commission assesses the experience to date of hospitals and beneficiaries in the FFS Medicare Acute Hospital Care at Home (AHCAH) program and reviews considerations for Medicare policy.

Approaches for updating clinician payments and incentivizing participation in alternative payment models

In Chapter 1, the Commission considers two approaches for updating FFS Medicare's PFS payment rates to adequately account for cost growth and to ensure Medicare beneficiaries maintain access to clinician services. The Commission also contemplates temporarily extending the bonus for participation in A–APMs.

Every year, the Commission assesses the adequacy of FFS payments made under the Medicare PFS and recommends an appropriate update to those payments in our annual March report to the Congress. As part of that process, the Commission measures beneficiaries' access to clinician care. For many years, the Commission has found that this access has been as good as, or better than, that of privately insured individuals; the share of clinicians who accept new Medicare patients has been comparable with the share who accept new privately insured patients; and volume of and spending on fee schedule services per beneficiary have consistently grown.

Nevertheless, the Commission is concerned about whether payments will remain adequate in the future. Payment rates are set to be flat in 2025 and, starting in 2026, increase by 0.75 percent per year for qualifying clinicians participating in A-APMs and by 0.25 percent for all other clinicians. Meanwhile, clinicians' input costs, as measured by the Medicare Economic Index (MEI), are expected to increase by an average of 2.3 percent per year from 2025 through 2033—exceeding the growth in PFS payment rates by more than has been the case over the past two decades. This larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat or stop participating in Medicare entirely. In addition, the growing differential between payment rates when a service is billed in a freestanding clinician office

versus a hospital outpatient department (HOPD) could encourage more services to be billed in the higher-paid HOPD setting and could spur additional vertical consolidation in the health care industry.

The Commission is also concerned about the upcoming sunsetting of participation bonuses for clinicians in A-APMs after 2026. To date, the A–APM participation bonus (currently set at 5 percent of a clinician's Medicare payments for fee schedule services) has always been larger than the highest adjustment available through the Merit-based Incentive Payment System (MIPS) (which has reached up to 2.34 percent)—helping to incentivize clinicians to participate in A–APMs. After 2026, as described above, A–APM participation bonuses will be eliminated in favor of the differential payment updates for clinicians depending on whether or not they are in an A–APM. In the initial years of differential updates, the higher updates for qualifying clinicians in A–APMs will produce a relatively weak incentive to participate in A–APMs. In 2027, for example, A–APM clinicians' payment rates will be only 1 percentage point higher than those of other clinicians. MIPS may therefore become the more attractive option for top-performing clinicians in coming years, depending on CMS's implementation decisions, because MIPS adjustments can reach as high as 9 percent under current law.

Given these concerns, the Commission is considering alternatives to current-law updates, such as replacing them with updates based on some measure of inflation and temporarily extending the current A–APM participation bonus.

Alternative approaches to updating PFS payment rates

One approach would be to update the practice expense portion of fee schedule payment rates by the hospital market basket, adjusted for productivity. This approach would attempt to address current differences in updates between the PFS and the hospital outpatient prospective payment system (OPPS): PFS payment rates are updated by statutorily specified percentages that are not linked to cost growth, while OPPS rates are updated by the hospital market basket (a measure of growth in hospital input costs). This approach defers consideration of automatic annual updates to the work component of fee schedule payments, but periodic updates to the work component could still occur (and would be addressed by the Commission's annual assessment of payment adequacy).

Under this approach, services for which practice expenses represent a large share of the total payment would see larger updates compared with services for which practice expenses represent a small share of the total payment. As a result, certain specialists (e.g., radiation oncologists, vascular surgeons, interventional radiologists, and dermatologists) would receive larger updates than primary care providers, behavioral health clinicians, and certain other types of specialists (e.g., hospitalists, emergency medicine physicians, and hospice and palliative care physicians). To limit the degree to which this approach would exacerbate inaccuracies in the relative values of different services' payment rates, it would be important to pair this update approach with efforts to revalue fee schedule services.

Another approach would update total fee schedule payment rates (including payments for both practice expense and clinician work) by the MEI (which includes a productivity adjustment) minus 1 percentage point. To avoid updates that are very low or negative, this approach could include an update floor equal to half of MEI. This approach would reflect the fact that PFS updates have averaged around MEI minus 1 percentage point for the previous two decades. The approach would update payment rates for all codes by the same factor in a given year, so the percentage updates would be the same across services and specialties. To improve payment accuracy for services with high practice expenses and limit incentives for vertical consolidation, this approach could be paired with efforts to rebase the MEI using more recent data, change the treatment of practice expenses under the fee schedule for services performed in facilities, or other reforms.

The first approach would require substantial operational changes in the way payment rates are set and updated over time and would tend to result in smaller payment rate increases for primary care and behavioral health clinicians compared with those for many specialists. The second approach would be simpler to implement and would reduce or eliminate the need for policymakers to revisit fee schedule update policy in the future to provide separate increases to the work portion of fee schedule payments. The Commission finds the features of the

second approach more desirable and will continue to develop this option in the future.

Maintaining incentives to participate in A–APMs

Under current law, clinicians in A–APMs receive a participation bonus worth 5 percent of their Medicare payments for fee schedule services from 2019 through 2024, a bonus worth 3.5 percent of these payments in 2025, and a bonus worth 1.88 percent of these payments in 2026. The Commission has discussed extending the bonus as one way to support participation in A–APMs. Extending the bonus for a few more years would help maintain clinician participation in A–APMs in the late 2020s, given uncertainty about the attractiveness of MIPS to clinicians in the coming years. Once the future direction of MIPS becomes clearer, a reassessment of the need for the A–APM participation bonus could be undertaken.

The Commission has also discussed restructuring the A–APM participation bonus to be based on a clinician's Medicare payments for fee schedule services for FFS Medicare beneficiaries in A–APMs (instead of a clinician's payments for all FFS Medicare beneficiaries, including beneficiaries not in A–APMs). This approach could be coupled with eliminating the requirement that a certain share of a clinician's payments or patients be in an A–APM to qualify for the bonus. Restructuring the bonus in this way would allow bonus payments for clinicians who participate in A–APMs but currently fail to qualify for the bonus.

Provider networks and prior authorization in Medicare Advantage

In Chapter 2, the Commission discusses the use of provider networks and prior authorization in MA plans, CMS's regulation of these tools, and the data that MA plans currently report in these areas.

The MA program allows Medicare beneficiaries who are enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional FFS program. The Commission has long held that MA presents opportunities to achieve higher-quality care at lower cost. Using provider networks and utilization management tools such as prior authorization, MA plans can shape the services and providers that enrollees can access. On the one hand, these tools have the potential to promote more efficient care. On the other hand, misapplication of these tools could lead to delays or denials of needed care. While CMS regulates both tools, limitations persist in current data collection and enforcement mechanisms. In the future, the Commission plans to explore the implications of provider networks and prior authorization on beneficiaries' access to care, quality of care, and cost.

Provider networks in MA

One key distinction between MA and FFS Medicare is that MA beneficiaries trade the free choice of any provider participating in Medicare for a more managed set of relationships with providers in an MA plan's network. Being "in network" means that a provider has agreed to furnish covered services to plan members at specified payment rates. Networks can have positive implications for both cost and quality, such as filtering out low-performing providers. However, it is important to ensure that plans provide adequate access to the full range of statutorily defined Medicare benefits.

CMS has network adequacy standards for MA contracts that consist of minimum numbers of providers, maximum travel time and distance to providers, and maximum wait times. Some of the standards vary by rurality. For example, beginning in contract year 2021, CMS reduced the percentage of beneficiaries who must reside within the maximum time and distance thresholds in non-urban counties. Lowering thresholds for network adequacy in rural areas may decrease barriers for MA plans to enter new markets, but the reductions likely result in access discrepancies between rural and urban beneficiaries.

Using a three-year review cycle, CMS verifies that plans are compliant with network adequacy criteria at the contract level. Audits can also be triggered under special circumstances, including when an enrollee files an access complaint. When gaps in a network are identified, MA organizations are notified by CMS and must either expand their network of providers or seek an exception to the network adequacy criteria. CMS denies a majority of these exception requests. CMS has the authority to impose sanctions for noncompliance with network adequacy standards but has never done so. However, new applications have been denied on this basis.

Plans' provider directories must be accurate in order for CMS to be able to assess network adequacy and for

beneficiaries to identify in-network sources of care. However, maintaining an accurate record of contracted providers can be administratively burdensome for both plans and providers. Because of the logistical challenges associated with keeping provider directories up to date and the potential adverse consequences of not doing so, CMS has proposed maintaining a national provider directory.

Prior authorization in MA

MA plans can require enrollees to obtain prior authorization to access certain services, a practice that is not widely used in FFS Medicare. Plans most often require prior authorization for relatively expensive services, such as certain Part B drugs, skilled nursing facility stays, and inpatient hospital stays. A recent study found that the use of prior authorizations by MA plans increased from 2009 to 2019 for most service categories. In 2023, nearly all MA enrollees were in plans that required prior authorization for some categories of services. Because prior authorization requirements can vary by service type and by plan, they can impact beneficiaries with certain conditions and some provider types and specialties more than others.

We analyzed the most recently available prior authorization determinations data that MA organizations report to CMS. In 2021, MA plans made about 37.5 million prior authorization determinations, or about 1.5 determinations per enrollee. Overall, we found that 95 percent of prior authorization requests had fully favorable decisions. The percentage of adverse prior authorization decisions varied across the largest MA organizations, with negative determination rates ranging from 3 percent to 12 percent. Providers or beneficiaries requested that MA plans redetermine 11 percent of negative prior authorization decisions in 2021. Eighty percent of those requests had fully favorable decisions. For those requests that had an unfavorable decision, an independent review entity upheld the MA plan's decision most of the time.

Prior authorization has been identified as a major source of provider administrative burden and can become a health risk for patients if it results in needed care being delayed or denied. Although only a small share of prior authorization requests have been denied, Office of Inspector General (OIG) audits suggest that many denied requests should have been approved. CMS has recently finalized several regulatory changes to address concerns about prior authorizations, such as requiring more transparency around MA organizations' internal coverage criteria and better communication of rationales for denied prior authorization requests.

Assessing data sources for measuring health care utilization by Medicare Advantage enrollees: Encounter data and other sources

In Chapter 3, using data from 2020 and 2021, the Commission assesses the relative completeness of MA encounter data and other data sources that contain information about MA enrollees' use of services.

Since 2012, MA plans have been required to submit to Medicare a record of each encounter that MA enrollees have with a health care provider. The Commission has long been interested in using MA encounter data to better understand plan practices and the services used by MA enrollees. This information could also be used to provide more rigorous oversight of Medicare's payments to MA plans—which reached $455 billion in 2023—and to ensure that the Medicare beneficiaries enrolled in an MA plan (now more than half of eligible beneficiaries) receive the full Medicare benefit. Lessons learned from MA encounter data could inform improvements to MA payment policy, facilitate comparison with traditional (FFS) Medicare, and generate new policy ideas that could be applied across the entire Medicare program. If validated for such purposes, encounter data could replace several of the data summarization and submission tasks that are currently conducted by MA plans, improving the consistency of the data used to administer the MA program.

However, in previous assessments, the Commission has found that MA encounter data do not include records of all items or services provided to MA enrollees. In 2019, the Commission recommended that the Congress direct the Secretary to (1) establish thresholds for the completeness and accuracy of MA encounter data; (2) evaluate MA plans' submitted data and provide feedback to organizations, including comparisons to external data sources; and (3) apply a withhold to plan payments that would be refunded to MA organizations that meet the established thresholds. The Commission also recommended instituting a mechanism for direct submission of provider claims to Medicare administrative contractors as a voluntary

option for all MA organizations that prefer this method, for MA organizations that fail to meet completeness thresholds, or for all MA organizations if program-wide thresholds are not achieved.

In this chapter, we find that encounter data completeness has incrementally improved since 2017 for some services but that generally the data remain incomplete. In addition, other data sources that contain information about MA enrollees' use of services also appear to be incomplete: In each of the data comparisons we conducted, we found records of services provided to MA enrollees that were missing from the comparator source.

We also assessed variation in the completeness of data across and within MA contracts. We found that the share of contracts reporting at least one encounter in all six service categories has improved since the early years of encounter data collection. Within MA contracts, we found wide ranges of completeness across service sectors, even among contracts with relatively high completeness for any one sector. Given these findings, we urge policymakers and researchers to carefully consider the potential impact of missing data when using encounter data to examine MA utilization.

Because nationally representative independent data sources with which to compare the encounter data are limited, the next best alternative is to compare encounter data with other plan-reported sources, such as plan quality and bid data. Comparing MA encounter data with other plan-generated data sources does not provide an independent validation of data completeness and accuracy, but the comparison can be used to assess the consistency of the information that plans submit to CMS. In this chapter, we also explore whether such comparisons can provide insights regarding the relative completeness of encounter data.

Our findings suggest that the information plans submit to CMS through separate reporting processes is not internally consistent and that there are technical factors that limit our ability to use the data to identify underreporting of encounter data. In our comparison of encounter data and Healthcare Effectiveness Data and Information Set® (HEDIS®) data, we found that HEDIS hospitalization data differed substantially from encounter data and that HEDIS was the main cause of this inconsistency. Our findings suggest that the encounter data are a more complete source for hospital utilization measures than HEDIS data.

Our analysis of bid data and encounter data also showed discrepancies between the two sources. The bid data that MA organizations submit annually to CMS include plan-calculated utilization rates that can be compared with rates calculated from encounter data. We found that, among bids that could be compared with encounter data, utilization rates based on encounter data were within 5 percent of the rates reported in plan bids for less than 40 percent of bids, comprising less than half of enrollees in the analysis. Encounter-based rates for inpatient and skilled nursing facility services were more than 5 percent below the bid-based rate for roughly one-third of bids analyzed (about 20 percent to 30 percent of enrollees in our analysis), suggesting that encounter data remain incomplete, particularly for some organizations.

In conducting the comparisons, we identified a series of factors that would limit the usefulness of bid data and HEDIS data for identifying underreporting of encounter data. For example, we found that HEDIS specifications (instructions for processing the data) exclude a significant fraction of hospitalizations. In comparing bid data and encounter data, we found that less than half of bids (encompassing less than half of enrollees in the analysis) met the criteria needed to conduct the comparison. Thus, bid data can, at best, be used to assess only a fraction of plan-reported data. Further analysis is needed to more fully consider the utility of comparing encounter data with bid data.

The encounter data have the potential to be a valuable tool for policymakers seeking to monitor, learn from, and improve the MA program. However, incomplete reporting of the data continues to limit their utility. The Commission will continue to consider approaches for working with the data in their current state, additional methods for validating the data, and policy options for improving the accuracy and completeness of the data.

Paying for software technologies in Medicare

In Chapter 4, the Commission reviews the FDA's process for clearing SaMD, examines Medicare's current coverage process and payments for medical device software under the payment systems for

Part A and Part B services, and discusses issues that policymakers should keep in mind when considering paying for medical software in FFS Medicare.

Software is increasingly important and pervasive in health care, driven by the availability of a multitude of technology platforms and the growing ease of access and distribution. Many types of clinical software are increasingly available to providers. These software products incorporate artificial intelligence (AI), which uses algorithms or models to perform tasks and exhibits behaviors such as learning, making decisions, and making predictions. A subset of AI known as machine learning uses computer algorithms to learn through data to perform a task without being explicitly programmed; this type of AI has become an important part of a growing number of medical devices. While many of these technologies are new, clinical software has been used to aid or augment clinical decision-making for decades.

In this chapter, we discuss software that performs functions that often categorize it as a medical device—software that is used for one or more medical purposes that diagnose or treat an illness or injury without being part of a hardware medical device. Even though the FDA classifies these technologies as SaMDs, for the purposes of this chapter we classify them into two distinct categories:

- Software as a service (SaaS), which is algorithm-driven software that is either cleared or approved by the FDA to help practitioners make clinical assessments, including decision support intervention software, clinical risk modeling, and computer-aided detection. These technologies often rely on complex algorithms or statistical predictive modeling to aid in the diagnosis or treatment of a patient's condition. Examples of Medicare-covered SaaS include LumineticsCore and fractional flow reserve derived from computed tomography.
- Prescription digital therapeutics (PDTs), which are software products that (1) receive market authorization (i.e., are either cleared or approved) by the FDA to manage or treat an injury or disease; (2) are prescribed by clinicians; (3) are typically administered by patients on a mobile phone, tablet, smartwatch, or similar technologies; and (4) primarily use software to diagnose or treat an illness or injury. Examples of PDTs include Parallel and NightWare.

We do not include remote monitoring technologies, health and wellness applications (apps), and health information technology systems in our definition of SaaS or PDT technologies. The development of SaaS and PDTs is relatively new and evolving, and terminology that is used to refer to such technologies is generally not well established. In this chapter, we use the terms *SaaS* and *PDT* when discussing issues related to Medicare's coverage and payment because CMS, other policymakers, and stakeholders often use this terminology when discussing such issues.

Before manufacturers of SaaS or PDT items can market a new product and seek Medicare coverage, they must comply with the requirements of the FDA, which applies the approval process for medical devices to the software products. The FDA uses three pathways to clear or approve SaaS or PDT items: premarket notification (PMN, also referred to as 510(k) clearance), De Novo classification, and premarket approval (PMA). Under the 510(k) pathway, the FDA clears a low- to moderate-risk device that a manufacturer demonstrates is "substantially equivalent," meaning that it is as safe and effective as another, similar device that is already on the market, referred to as the "predicate device." Under the De Novo pathway, the FDA clears a low- to moderate-risk medical device for which there is no FDA-approved predicate device. The PMA pathway is the most stringent FDA process of scientific and regulatory review. The FDA approves devices under the PMA pathway if there are sufficient clinical data to demonstrate that the device is safe and effective.

After receiving clearance or approval from the FDA, a manufacturer of a SaaS or PDT item can seek Medicare coverage for its product. Medicare covers items and services under Part A or Part B that are:

- included in a Medicare benefit category, such as inpatient hospital services and hospice care under Part A and durable medical equipment (DME), immunosuppressive drugs, and outpatient services under Part B;
- not statutorily excluded (excluded services and supplies are, for instance, deemed medically unreasonable and unnecessary);

- reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, as indicated under the Social Security Act; and
- approved or cleared by the FDA, which is specific to Part B drugs, devices, and certain laboratory tests.

All items and services covered under Part A or Part B must also be covered in Part C (Medicare Advantage) except for hospice care, which is carved out of MA. In addition, all items and services (including SaaS and PDT items) that are covered under Medicare are either separately payable or packaged. The Medicare payment systems that cover SaaS and PDT items include the outpatient prospective payment system (PPS), the PFS, the inpatient PPS, the DME fee schedule, and the end-stage renal disease PPS.

CMS has been deliberate in deciding whether to cover SaaS and PDT items that have FDA clearance or approval. Since 2018, FFS Medicare has covered and paid for SaaS in inpatient and outpatient hospital settings and in clinician offices. However, FFS Medicare generally does not cover PDTs because the Medicare statute lacks a separate benefit category for PDTs and the technology is not consistent with FFS Medicare's definition of DME. As of 2022, providers' use of the medical software that Medicare does cover had been relatively low.

A key issue facing the FFS Medicare program is how medical software that is generally separate from the medical device should be paid for. For the hospital inpatient and outpatient PPSs and the end-stage renal disease PPS, the Commission has long supported larger payment bundles because they give providers flexibility in the provision of care and incentives to use the most cost-efficient methods. By contrast, paying separately for software technologies can discourage providers from demanding lower prices for AI technologies and lead to overuse. Unfortunately, for the various FFS Medicare fee schedules (e.g., the PFS and DME fee schedules), in which the program generally pays for each service furnished, Medicare currently has few pricing tools that would help strike a balance between maintaining incentives for innovation and ensuring affordability. The Commission will continue to deliberate on appropriate payment for software technologies under FFS Medicare.

Considering ways to lower Medicare payment rates for select conditions in inpatient rehabilitation facilities

In Chapter 5, the Commission considers alternative approaches to lower Medicare's FFS payment rates to IRFs for beneficiaries with select conditions.

Payments to IRFs are high relative to the cost of care, and Medicare margins have exceeded 10 percent for the past 20 years. In 2018, OIG concluded that the high profitability may have created incentives for IRFs to admit patients inappropriately. The Commission has recommended since 2009 that the Congress reduce the aggregate level of FFS payments to IRFs.

To differentiate IRFs from acute care hospitals, 60 percent of an IRF's admissions must be patients with 1 of 13 conditions (or have specified comorbidities and patient characteristics). We refer to these conditions as "contributing to the compliance threshold" because they count toward an IRF meeting the 60 percent compliance threshold. The remainder of an IRF's admissions can be patients with other conditions that do not contribute to the compliance threshold. Though some have questioned whether a clinical condition is sufficient to identify patients who require intensive rehabilitation, CMS has consistently relied on the list of 13 conditions to identify the types of cases that IRFs should be primarily engaged in treating because those conditions typically require intensive rehabilitation.

If it were possible to perfectly identify patients who do not require IRF care and could be treated in a skilled nursing facility (SNF), policymakers could establish SNF rates for them or narrow the payment differences between IRFs and SNFs. A targeted reduction would be in lieu of an across-the-board reduction to IRF payment rates. However, differentiating patients who do or do not require IRF-level care is difficult without reviewing medical records. After conducting such reviews, CMS and OIG found that a substantial share of cases admitted to IRFs did not meet medical necessity criteria and documentation requirements.

To assess the impacts of lowering payments for select conditions, we used cases that do not contribute to the compliance threshold as a proxy for cases that may not require IRF-level care. This approach is imperfect because this group can include patients who do require intensive rehabilitation; similarly, it is possible

that some patients who contribute to meeting the compliance threshold do not require this level of care. Comparing patients treated in IRFs and SNFs and their outcomes is difficult due to unobserved differences in the patients admitted to the two settings, but using this proxy allows us to compare patients treated in IRFs and SNFs.

We found that while patients treated in the two settings were similar across many dimensions, those treated in IRFs tended to be younger and less medically complex and impaired. Drawing conclusions about differences in the outcomes of patients treated in IRFs and SNFs was more challenging. Even with risk adjustment, underlying differences in the patient populations, not the care they received, could partly explain the results. Because IRFs are licensed as hospitals and their users face different coverage rules, we would expect certain outcomes to differ. Interviews with hospital discharge planners identified many factors that influence the placement of patients in one setting or the other. Except for stroke, few conditions have evidence-based guidelines to assist discharge planners in making placement decisions.

Without being able to draw firm conclusions about differences in outcomes for patients treated in IRFs and SNFs, we evaluated lowering IRF payment rates for patients with noncompliant conditions. We considered three approaches. In one, rates would be lowered to the amount paid to SNFs. The resulting rates would not cover IRFs' costs, which might encourage IRFs to scale back admissions of these patients. Further, to lower their costs, IRFs might reduce staffing and care delivery that could worsen the care they provide. Because patients with conditions that do not contribute to the compliance threshold can include those who require IRF-level care, the very low payment rates could disrupt their care. In the second approach, IRF payment rates would be lowered so that in aggregate they would equal the cost of care. In the third, payment rates would be based on a blend of current rates and rates that equal the cost of care. Because these last two approaches would involve much smaller reductions in payment rates than SNF-based rates, IRFs would have less incentive to disrupt or change the care provided to beneficiaries.

In assessing whether a targeted reduction was a reasonable approach to lower IRF payments, the Commission considered several factors. First, the list of conditions that contribute to compliance is imperfect for identifying beneficiaries who require IRF-level care. As a result, reductions targeted at patients with conditions that do not contribute to the compliance threshold could disrupt care for some beneficiaries. Second, cases that did and did not contribute to the compliance threshold were equally profitable overall. It was not clear that rates should be lowered for only a subset of conditions. Third, unmeasured differences in the patients treated in IRFs and SNFs undermined our ability to draw conclusions about the characteristics and outcomes of the patients treated in each setting. Taken together, these factors persuaded the Commission that our standing recommendation to lower payment rates for all cases was the best course of action. We will reevaluate our recommendation about the aggregate level of payments in December 2024 when we consider the adequacy of Medicare's payments to IRFs for fiscal year 2026.

Aside from the level of Medicare's payments, CMS, in conjunction with the Congress, could take several steps to improve the definition and identification of cases that do and do not require IRF care. The list of conditions contributing to the compliance threshold could be updated on a regular basis to include conditions that typically benefit from intensive therapy and exclude conditions that do not. An ongoing CMS demonstration that is reviewing 100 percent of claims in selected states might provide CMS with useful information for preventing unnecessary admissions. CMS may also need to continue to educate providers and claims reviewers about medical necessity and documentation rules. With additional funds, CMS could increase its auditing of IRF admissions.

Medicare's Acute Hospital Care at Home program

In Chapter 6, the Commission assesses the experience to date of hospitals and beneficiaries in the FFS Medicare AHCAH program and reviews considerations for Medicare policy.

Acute care hospital services are an important benefit for Medicare beneficiaries who need inpatient clinical care or close medical supervision. For many years, hospitals and payers have experimented with providing this care through a modified acute care

benefit, referred to as "hospital at home" (HAH), which provides acute care in a beneficiary's home rather than a traditional stay in a hospital. Proponents of HAH contend that it can provide better care at lower costs to the health care system, though past evaluations of HAH programs have not conclusively demonstrated these outcomes. Concerns about a shortage of acute care hospital capacity during the coronavirus pandemic led CMS to establish the AHCAH program in FFS Medicare. Though the program was originally set to expire at the conclusion of the coronavirus public health emergency (PHE), the Congress extended the program through December 31, 2024, in the Consolidated Appropriations Act, 2023.

Under the AHCAH program, hospitals apply to CMS to provide the inpatient acute care benefit at home. The AHCAH program waives some requirements of Medicare's hospital conditions of participation but adds other requirements unique to home care, such as requiring two daily in-home visits by clinical staff. The payment for AHCAH cases is the same as the amount Medicare would have paid for an in-hospital acute care stay under the inpatient prospective payment systems (IPPS). Hospitals participating in the AHCAH program develop, with CMS review, the clinical and social criteria for patient inclusion and exclusion.

CMS reported that as of April 2024, about 23,000 AHCAH discharges have occurred (including both Medicare and Medicaid beneficiaries) and 328 hospitals have been approved to participate. However, past experience suggests that many approved hospitals may not have implemented programs. For example, CMS's report on the AHCAH program in 2022 included 284 hospitals, but only 105 hospitals, or 37 percent, reported at least one discharge under the program. These hospitals reported approximately 6,100 discharges (less than 0.1 percent of all IPPS discharges), for an average of about 59 patients per active hospital. In 2022, AHCAH volume was concentrated among those hospitals, with 26 hospitals accounting for 71 percent of the AHCAH discharges.

Hospitals active in AHCAH in 2022 tended to have higher all-payer patient volume, higher occupancy, and nonprofit ownership status, and they tended to be located in urban areas. The reported rates of patient mortality and escalations from the home to the hospital were low. The two most common diagnoses for AHCAH discharges in fiscal year 2022 were respiratory infection and heart failure.

Many aspects of AHCAH are new and evolving, which creates opportunities for experimentation and may ease implementation but could also result in risks for patients or in unmet patient needs. In interviews with Commission staff, hospitals participating in the AHCAH program noted challenges in getting their programs started. In addition, hospitals described experiences with beneficiaries declining AHCAH care (though the rates of patient uptake varied by hospital), citing beneficiary lack of familiarity with the model and distrust.

Though AHCAH probably played a negligible role in increasing hospital capacity during the PHE, the limited uptake likely reflects the implementation challenges that hospitals faced. The Commission's interviews with hospitals participating in AHCAH found that beneficiaries receive fewer services (such as physician consults and laboratory tests) during an AHCAH stay than during a conventional inpatient stay. Nevertheless, the cost per unit of service may be higher due to the additional costs and inefficiencies of providing care to patients in their homes. Whether AHCAH can provide value to beneficiaries and the Medicare program—through better outcomes and reduced Medicare expenditures for follow-on care—has yet to be conclusively determined.

If the program continues, CMS will want to review many of the aspects of care provided under the program. Understanding how these factors impact beneficiaries' care may help identify areas where the AHCAH model needs refinement. More important, policymakers will need to consider how to (1) measure outcomes for the program so as to safeguard quality of care; (2) ensure that beneficiaries using AHCAH require that level of care (and not a lower, less costly, level of care, such as that provided by home health agencies); and (3) set FFS payments appropriately. ■